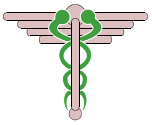
Oral Roberts University

Flexible Benefit Plan

- **Pre-Tax Premium Program**

- **Health Care Reimbursement Account**



- **Dependent Care Reimbursement Account**

A TAX SAVINGS PLAN

You can realize substantial tax savings by enrolling in the Oral Roberts University Flexible Benefit Plan. You can participate in the **Pre-Tax Premium Program**, the **Health Care Reimbursement Account** and the **Dependent Care Reimbursement Account**. The money you put into these accounts is withheld before taxes are calculated. You never pay Federal Income Tax, Social Security Tax, Medicare or State Income Tax (in most states) on the elected amounts. This means you will have more spendable income in your pocket.

The annual open enrollment is now underway for the Plan Year
January 1, 2012 through December 31, 2012.

Please return enrollment form to Benefits Department by Monday, December 5, 2011.

Note: *This booklet is a summary of your Flexible Plan Benefits. For more detailed information, review the Summary Plan Description provided by your Employer. Benefits will only be payable in accordance with the terms and conditions of your Employer's plan documents.*

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OPEN ENROLLMENT

Open Enrollment is generally the only time of year you can change your insurance plan coverages and enroll in the reimbursement accounts. Open Enrollment for the plan year January 1, 2012 to December 31, 2012 is now underway. This is the time to make any of the following changes for coverage effective January 1, 2012.

- Enroll in the Health Care Reimbursement Account for the year January 1, 2012 to December 31, 2012.
- Enroll in the Dependent Care Reimbursement Account for the year January 1, 2012 to December 31, 2012.
- Enroll in or change your medical plan
- Enroll in or change your dental plan
- Enroll in or drop any other insurance plans with premiums deducted on a pre-tax basis
- Enroll or drop dependents

TAX SAVINGS ILLUSTRATION

This example is to illustrate how you can ***increase*** your ***spendable income*** by electing to participate in the Pre-Tax Premium Plan, the Healthcare Reimbursement Plan, or the Dependent Care Reimbursement Plan. By reducing taxable income, you reduce your taxes and increase the amount of money you have available for your enjoyment.

	Non Participating	Participating	Tax reduction	Reimbursement Accounts
Annual Salary	$ 25,000	$ 25,000		
Pretax Premiums		(1,200)		
Health Care Reimbursement Account		(1,800)		1,800
Dependent Care Reimbursement Account	-	(2,000)		2,000
Taxable income	**25,000**	**20,000**		
Estimated Taxes (30%)	(7,500)	(6,000)	(1,500)	
Medical premiums	(1,200)	-		
Net take home pay	16,300	14,000		
Pay medical expenses	(1,800)	(1,800)		
Pay dependent care expenses	(2,000)	(2,000)		
Submit claims for reimbursement	-	3,800	-	(3,800)
SPENDABLE INCOME	***$ 12,500***	***$ 14,000***	***$ 1,500***	

In this example you have **$1,500 more** to spend this year ***and*** you have the full amount of your Health Care and Dependent Care Deductions to spend on your Health Care and Dependent Care expenses.

No taxes are taken from your deduction, and you do not pay taxes on the reimbursement.

PRE-TAX PREMIUM PROGRAM

You can elect to have the following premiums deducted from your pay on a pre-tax basis. This means the premiums are deducted before payroll taxes are computed.

- Medical Premiums
- Dental Premiums

Having your premiums deducted pre-tax can result in a tax savings of 28¢ to 42¢ (depending on your personal tax bracket) for every dollar of your premium amount. See the above tax savings illustration to see how deducting your premiums on a pre-tax basis can increase your spendable income. The Pre-Tax Premium Program is separate from the Health Care and Dependent Care Reimbursement Accounts. By electing your Insurance coverages, you are electing to participate in the Pre-Tax Premium Program.

HEALTH CARE REIMBURSEMENT ACCOUNT

Although your Employer's health care program may pay many of your health related expenses, all of your medical, dental or vision expenses may not be covered in full. You may also face expenses during the Plan Year that are not covered by other plans and must be paid out of your pocket. Examples of out-of-pocket expenses that can be reimbursed to you include:

- insurance deductibles
- co-payments for office visits
- co-payments for prescription drugs
- eye exams
- contact lenses
- dental expenses
- eye glasses
- lens solutions
- hearing expenses

*(For more detail, see the **Eligible and Ineligible Health Care Expenses** listed on page 5.)*

How Does It Work?

1. You may elect to contribute any amount from $100 to $2,500 to your Health Care Reimbursement Account for the Plan Year January 1, 2012 to December 31, 2012.
2. Beginning in January, an incremental amount (determined on the worksheet below) will be deducted pre-tax each payday and set aside in a special account.
3. Your money will be reimbursed to you once you have incurred the expense and provided documentation through the claim filing process. *(See **Filing a Claim** on page 9.)*
4. To be eligible for reimbursement, health care expenses must:
   - be incurred by you, your spouse, or a child through age 26 during the Plan Year.
   - not be reimbursable from any other source
   - not be deducted on your Federal income tax return
   - qualify as a deductible medical expense under IRC. §213 or as described in IRS Publication 502
5. The total amount you elect to contribute to your Health Care Reimbursement Account for the 12 month period will be available for reimbursement to you at any time during the plan year.
6. Your election may **not** be changed during the Plan Year.
7. Any money remaining in your Health Care Reimbursement Account after February 28, 2013 will be forfeited. This is known as the **"use it or lose it"** rule.

How to Enroll:

- If you are currently enrolled, you **must** re-enroll to participate. Enrollment does not continue from year to year.
- Review the list of ***Eligible and Ineligible Medical Expenses*** on page 5 and ***Over The Counter Items*** on page 6.
- Use the worksheet below to estimate your out-of-pocket expenses for the year beginning January 1, 2012.
- If you will incur **orthodontic** expenses, use the worksheet on page 17 to calculate the amount eligible for reimbursement during the plan year.
- Calculate your annual and your per pay period deduction amounts below.
- Enter your **per pay period election amount** on your ***Oral Roberts University Enrollment Form.***

HEALTH CARE REIMBURSEMENT ACCOUNT WORKSHEET

List out of pocket expenses you are certain to incur for you, your spouse, and eligible dependents from ***January 1, 2012 to December 31, 2012.***

Medical deductibles		$
Office visit co-pays		
Prescription drug co-pays		
Dental deductibles		
Dental co-pays		
Eye exams		
Eye glasses, contact lenses and solutions		
Lasik eye surgery		
Hearing exams and hearing aids		
Orthodontia expense (see worksheet pg 17)		
Over the Counter Items		
ANNUAL TOTAL	**(Min $100 Maximum $2,500)**	$
Divide ANNUAL TOTAL by 26	**(Deductions taken per pay period)**	

HEALTH CARE REIMBURSEMENT ACCOUNT

Eligible and Ineligible Health Care Expenses

The following categorizes medical expenses as ***eligible or ineligible*** to be reimbursed under this program. This list is not all inclusive. If you have a question on an expense that is not listed, **call** Benefit Resources at (918) 481-6161 or 1(800) 339-7493.

Eligible Expenses

.Acupuncture	.Nurse's services, domestic
.Alcohol/drug addiction recovery	.Obstetrical expenses
.Ambulance	.Operations, legal
.Artificial limbs	.Optometrist fees
.Artificial teeth	.Orthopedic shoes
.Birth control pills (prescribed)	.Orthodontia costs
.Braces	.Osteopath fees
.Braille-books and magazines	.Over the Counter items (see page 6)
.Care for mentally handicapped child	.Over the Counter drugs with Healthcare Provider diagnosis
.Childbirth classes (mother's cost)	.Oxygen equipment
.Chiropractic fees	.Physician fees
.Christian Science treatment	.Physician-prescribed equipment and maintenance
.Co-insurance (costs applied to it)	.**Prescription** medicine (including vitamins and contraceptives)
.Contact lens (and solutions)	.Prosthesis
.Costs for physical or mental illness confinements	.Psychiatric fees
.Crutches	.Psychologist fees
.Deductibles (costs applied to it)	.Radial Keratotomy Surgery
.Dental fees	.Remedial reading (neurological)
.Dentures	.Routine physicals and other non-diagnostic services
.Diagnostic fees	.Service animal, seeing-eye or deaf
.Drugs (**prescription**)	.Sexual dysfunction treatment
.Dyslexia, language training	**.Smoking cessation programs**
.Eyeglasses (prescribed) and exams	.Special communication equipment for blind or deaf
.Handicapped person's special school	.Special education for blind or deaf
.Hearing device and batteries	.Special home for retarded person
.Hospital care (medical services)	.Special plumbing for handicapped
.Immunizations/vaccinations	.Speech therapy
.Insulin	.Sterilization operation, legal
.Iron lung	.Surgical fees, legal
.Laboratory fees	.Therapy treatments (prescribed)
.Laetrile, legal use (prescribed)	.Vitamins (**prescriptions only**)
.Lasik eye surgery	.Weight Loss Programs (Prescribed by a Physician)
.Life fee to retirement home for medical care	.Wheel chair
.Massage therapy (prescribed treatment)	.X-rays
.Nurse's fees	

Ineligible Expenses

.Cosmetic Procedures or Prescriptions	Insurance Premiums (including COBRA)
.Cosmetics or toiletries	.Over the counter items for general health and well being
.Dancing Lessons	.Propecia
.Diaper Service	.Renova (anti-wrinkle cream)
.Elective Cosmetic Surgery	.Retin-A (**unless** diagnosis of acne)
.Exercise Programs and Health Spa Membership	.Rogaine
.Health Club Dues	.Swimming Lessons
.Household Help	.Swimming Pools, Saunas, or Exercise Equipment
.Marriage or Family Counseling	.Trips or Vacations
.Maternity Clothing	**.Teeth whitening/Teeth bleaching**

Benefit Resources, Inc
OVER-THE-COUNTER (OTC) ITEMS

On September 3, 2010, the Internal Revenue Service issued Notice 2010-59 and Revenue Ruling 2010-23 which explain in detail how the **Patient Protection and Affordable Care Act (PPACA)** will impact the purchase of OTC medicines and drugs. PPACA mandates that expenses incurred for OTC medicines and drugs (with the exception of insulin) will not be eligible for reimbursement under a health FSA or HRA unless you have a prescription.

Items REMOVED from the ELIGIBLE list unless you have a prescription

- Acid controllers
- Allergy & Sinus
- Antibiotic products
- Anti-diarrheals
- Anti-gas
- Anti-itch & insect bite
- Antiparasitic treatments
- Baby rash ointments/creams
- Cold sore remedies
- Cough, cold & flu
- Digestive aids
- Feminine anti-fungal/itch
- Hemorrhoidal preps
- Laxatives
- Motion sickness
- Pain relief
- Respiratory treatments
- Sleep aids & sedatives
- Stomach remedies

ELIGIBLE ITEMS

These items are not considered a medicine or drug and will not require a prescription for reimbursement

Acne creams
Anti-fungal foot medication
Antiseptics/ wound cleaners
Band Aids
Braces and supports
Catheters
Condoms
Denture adhesive
Diabetic testing and aids
Diagnostic tests and monitors
Elastic bandages and wraps
Eye care/contact lens supplies
Family planning kits
Fiber laxatives
First aid supplies
Hearing aid batteries
Infant electrolytes
Infant teething pain supplies
Insulin/diabetic supplies
Nebulizers
Orthopedic aids
Ostomy products
Reading glasses
Smoking deterrents
Syringes
Thermometers
Wheelchairs
Walkers and canes

EXCLUDED ITEMS

Items that are toiletries or cosmetics and are primarily for general health and well being

- Chapstick
- Deodorants
- Ensure
- Eye makeup
- Face cream
- Facial makeup
- Fingernail polish
- Hair color
- Hand lotions
- Lipsticks
- Perfumes
- Permanent waves
- Shampoos (including medicated)
- Shaving cream
- Shaving lotion
- Skin moisturizers
- Suntan lotion
- **Toothbrush (including electric)**
- **Toothpaste**
- Vitamins
- Weight loss food replacements

DEPENDENT CARE REIMBURSEMENT ACCOUNT

A Dependent Care Reimbursement Account is a great opportunity for people who have child care or elder care costs. Instead of claiming these expenses on your annual income tax return, you can set aside up to $5,000* of your salary each year ($2,500 if married filing separately) in your Dependent Care Reimbursement Account. The tax advantage on the amount you put in this account is realized immediately. You do not need to wait until filing your income tax return for your benefit.

How Does it Work?

1. You may elect to contribute any amount from $100 to $5,000 to your Dependent Care Reimbursement Account for the Plan Year January 1, 2012 to December 31, 2012.
2. Beginning in January, an incremental amount (determined on the worksheet below) will be deducted pre-tax each payday and set aside in a special account.
3. Your money will be reimbursed to you once you have incurred the expense and provided documentation through the claim filing process. *(See **Filing a Claim** on page 10.)*
4. To be eligible for reimbursement, the expense must qualify as an eligible expense. See page 8 for ***Eligible Expenses.***
5. Your claim will be reimbursed up to the amount in your account at any given time.
6. Due to IRS regulations regarding reporting and disclosure, all reimbursements are made payable to the plan participant. Benefit Resources, Inc. will not make reimbursements payable directly to service providers.
7. Your election may be changed during the Plan Year only if you experience a ***Change in Status*** *(see page 8)* event. The change in your election must be consistent with the ***Change in Status*** event.
8. Any money remaining in your Dependent Care Reimbursement Account after February 28, 2013 will be forfeited. This is known as the **"use it or lose it"** rule.

How to Enroll:

- If you are currently enrolled, you **must** re-enroll to participate. Enrollment does not continue from year to year.
- Review the rules for ***Eligible Expenses*** on page 8.
- Use the worksheet below to estimate your eligible dependent care expenses for the year January 1, 2012 to December 31, 2012.
- Calculate your annual and per pay period deduction amounts below.
- $5,000* ($2,500 if married filing separately) is the maximum you can contribute to your Dependent Care Reimbursement Account for the year January 1, 2012 to December 31, 2012.
- Enter your per pay period election amount on your ***Oral Roberts University Enrollment Form.***

DEPENDENT CARE REIMBURSEMENT ACCOUNT WORKSHEET

List eligible dependent care expenses you will incur from ***January 1, 2012 through December 31, 2012.***
Remember to adjust your expenses for certain times of the year.

January		
February		
March *(Spring break)*		
April		
May *(Summer begins)*		
June *(Summer*)		
July *(Summer)*		
August (*School begins)*		
September		
October		
November *(Thanksgiving)*		
December *(Winter break)*		
ANNUAL TOTAL	**(Minimum $100 Maximum $5,000*)**	$
Divide ANNUAL TOTAL by 26	(Deductions taken twice per month **beginning in January**)	

If both you and your spouse participate in Dependent Care Reimbursement, the maximum combined election is $5,000.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

ELIGIBLE EXPENSES:

Dependent care expenses **must meet all** of the following conditions to be eligible expenses under the Dependent Care Reimbursement Plan:

1. The expenses must be incurred for services rendered after the date of your election to receive Dependent Care Expense Reimbursement, and during the Plan Year to which your election applies.
2. Each individual for whom you incur the expenses must be:
   - a dependent age 12 or under whom you can claim as a dependent** on your personal tax return.
   - a spouse or other tax dependent (such as an elderly parent) who is physically or mentally incapable of caring for himself or herself.
   - To find out who is a dependent, see IRS Publication 501 'Exemptions, Standard Deduction, and Filing Information.'
     See IRS Publication 503 for **Exception for Children of Divorced or Separated Parents
3. The expenses must be incurred for the care of a dependent (as described above), or for related household services, **and** incurred to enable you and your spouse (if married) to work or look for work.
4. If the expenses for dependent care are incurred for services outside your household, such dependent must reside in your home at least 8 hours per day. Charges for overnight stays are not eligible.
5. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.
6. The expenses must not be paid or payable to a child of yours who is under age 19 or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.
7. Annual reimbursement must not exceed the lesser of the following limits:
   a) $5,000*
   b) $2,500, if you are married but you and your spouse file separate tax returns.
   c) Your taxable compensation (after your Salary Reduction under the Plan).
   d) If you are married, your spouse's actual or deemed earned income.
   For purposes of (d) above, your spouse will be deemed to have earned income of $250 ($500 if you have two or more Dependents described in paragraph 2 above), for each month in which your Spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full time student.
8. You must supply the taxpayer ID number for each dependent care service provider to the IRS by completing and attaching the Form 2441 to your annual tax return.
9. Expenses related to overnight camps and private tuition are not considered eligible expenses under the plan.

ELECTION CHANGES:

- Your Pre-Tax Insurance Premium election and your Dependent Care election may only be changed if a ***Change in Status*** will result in the gain or loss of eligibility for coverage of the participant or the participant's spouse or dependent. The election change must be consistent with that gain or loss of eligibility for coverage.
- *A **Change in Status*** shall only include the following events or other events permitted by Treasury regulations:
  1) Legal Marital Status: marriage, divorce, separation, or the death of a spouse;
  2) Number of Dependents: birth, adoption, placement for adoption, or death of a dependent;
  3) Employment Status Change of the Participant, Participant's Spouse or Dependents: commencement or termination of employment, new or different work hours, change due to a strike, change from full-time to part-time (or vice versa), beginning or end of an unpaid leave of absence, or change in worksite. Also, if employment status affects eligibility under the plan, then that change constitutes a status change (e.g. salaried to hourly);
  4) Dependent satisfies or ceases to satisfy eligibility requirements: attainment of age, student status, or any similar circumstance;
  5) Residency: change in the place of residence of the Participant, spouse or dependent.
- Changes in cost or coverage:
  1) Cost:
     a) Automatic election changes may be made if the cost of a qualified benefit plan increases or decreases.
     b) For a significant increase in the cost of coverage, employees may be permitted to increase their payments or to revoke their election and, in lieu thereof, receive coverage under another benefit package option that provides similar coverage.
     c) For dependent care assistance, election changes may not be made due to a change in cost if the provider is a relative of the employee.
  2) Coverage:
     a) If significantly curtailed or ceases, employee may revoke election for that coverage and make a new election on a prospective basis for coverage under another benefit package providing similar coverage.
     b) If a benefit is added or eliminated, election changes may be made to add (or eliminate) the benefit and make a corresponding election with respect to other benefits that provide similar coverage.
- Change in Status rules do not apply to Health Care Reimbursement Accounts.

FILING A CLAIM

HEALTH CARE REIMBURSEMENT ACCOUNT

1) Co-payments:
   a) Complete a Benefit Resources Health Care Reimbursement Account Claim Form.
   b) Attach the co-payment documentation with the following information to the Health Care Reimbursement Claim Form.
      i) Date services were provided ii) Amount charged for service iii) Name of person receiving services
      iv) Service provider's name v) Nature of services provided
   c) Sign and date the Health Care Reimbursement Account Claim Form.
   d) Make a copy of your claim and your documentation.
   e) Submit your claim and documentation to Benefit Resources.
   f) You will be reimbursed all out-of-pocket eligible expenses up to your annual election. *(Minimum check amount $25.00)*

2) Expenses covered by insurance *(including amounts that are applied to your deductible):*
   a) File your claim with your insurance provider.
   b) They will send you an Explanation of Benefits (EOB) report that will document how the charges were applied to your deductible and /or coinsurance.
   c) Complete a Benefit Resources Health Care Reimbursement Account Claim Form.
   d) Attach the EOB to the Health Care Reimbursement Account Claim Form.
   e) Sign and date the Health Care Reimbursement Account Claim Form.
   f) Make a copy of your claim and your documentation.
   g) Submit your claim and documentation to Benefit Resources.
   h) You will be reimbursed all out-of-pocket eligible expenses up to your annual election. *(Minimum check amount $25.00)*

3) Expenses **NOT** covered by insurance (such as eyeglasses, dental expenses, hearing aid, etc.)
   a) Complete a Benefit Resources Health Care Reimbursement Account Claim Form.
   b) Attach the provider's statement of services to a Health Care Reimbursement Account Claim Form
   c) Provider's statement of services must contain the following information:
      i) Date services were provided ii) Amount charged for service iii) Name of person receiving services
      iv) Service provider's name v) Nature of services provided
   b) Sign and date the Health Care Reimbursement Account Claim Form.
   c) Make a copy of your claim and your documentation.
   d) Submit your claim and documentation to Benefit Resources.
   e) You will be reimbursed all out-of-pocket eligible expenses up to your annual election. *(Minimum check amount $25.00*)

2) Orthodontia Expenses**:**
   a) Have your orthodontist complete the '*Orthodontia PRO RATA Worksheet and Claim Form'* on page 17. This will document the eligible out-of-pocket costs for the Plan Year. **This worksheet needs to be done each plan year.**
   b. **If treatment is covered by insurance**: Attach the Preauthorization Worksheet from your insurance provider to the claim form. Sign and date the claim form before sending to Benefit Resources, Inc. Your out-of-pocket obligation will be prorated over the life of treatment to arrive at a monthly out-of-pocket amount. You will automatically be reimbursed monthly for that amount. You do not need to file monthly claims.

      OR

      In lieu of the above, submit each Orthodontia EOB and you will be reimbursed accordingly.

   c. **If treatment is *not* covered by insurance:** Sign and date the worksheet/claim form before sending to Benefit Resources, Inc. Each month you will automatically be reimbursed the amount as stated on the Orthodontia Worksheet/Claim Form. You do not need to file monthly claims.

3) Obstetric Expenses:
   a) **After** the expense has been incurred (**the birth of the baby**) submit your EOB (Explanation of Benefits) with the *Health Care Reimbursement Account Claim Form* on page 15. If birth is not covered by your insurance, submit itemized statements from the hospital and doctors.
   b) Sign and date the Health Care Reimbursement Account Claim Form.
   c) Make a copy of your claim and your documentation for your records.
   d) Submit your claim and documentation to Benefit Resources.
   e) You will be reimbursed your eligible expense up to your annual election. *(Minimum check amount $25.00*)

CLAIM FORMS CAN BE DOWNLOADED AT www.britulsa.com

FILING A CLAIM

DEPENDENT CARE REIMBURSEMENT ACCOUNT

1) Complete the Participant information on the Benefit Resources Dependent Care Reimbursement Account Claim Form.
2) Complete the following information on the Benefit Resources Dependent Care Reimbursement Claim Form:
   a) Name of dependent receiving care
   b) Date(s) care was provided
   c) Name of service provider
   d) Address of service provider
   e) Social Security or Employer I.D. number of the provider
   f) Amount of the charge
3) Have the day care provider sign the claim form.
4) The employee must sign the Dependent Day Care Claim Form.
5) Make a copy for your records.
6) Submit the Claim Form to Benefit Resources. *(Minimum check amount $25.00)*

OR

1) Complete the Participant information on the Benefit Resources Dependent Care Reimbursement Account Claim Form.
2) Attach receipts to the Dependent Care Reimbursement Account Claim Form. Be sure the receipts include the following information:
   a) Name of dependent receiving care
   b) Date(s) care was provided
   c) Name of service provider
   d) Address of service provider
   e) Social Security or Employer I.D. number of the provider
   f) Amount of the charge
3) The employee must sign the Dependent Day Care Claim Form.
4) Make a copy for your records.
5) Submit the Claim Form to Benefit Resources. *(Minimum check amount $25.00)*

CLAIM FORMS CAN BE DOWNLOADED AT www.britulsa.com

TERMINATION OF EMPLOYMENT

If your employment should terminate during the Plan Year (either voluntarily or involuntarily), you can submit claims for services incurred up to your date of termination. Your Human Resource Department will inform you whether or not you are eligible for COBRA for the **Health Care Reimbursement Account**. The COBRA information you receive from your employer will tell you how you can continue your participation in the **Health Care Reimbursement Account.** If you elect COBRA, you can submit claims incurred up to the termination of your COBRA coverage.

If you are a participant in the **Dependent Care Reimbursement Account** and you have money remaining in your account, you may submit claims for eligible expenses incurred during the Plan Year until the end of the run-off period.

END OF YEAR DEADLINE FOR FILING CLAIMS

The deadline for filing claims is 60 days following the end of the Plan Year. The expense must be incurred ***during*** the Plan Year, but can be submitted during the run-off period (the 60 day period following the end of the Plan Year). Any monies remaining in your account at the end of the run-off period will be forfeited. It cannot be returned to you or carried over to the next Plan Year.

Benefit Resources, Inc.
4775 E. 91st Street, Suite 100
Tulsa, OK 74137-2805
Phone: (918) 481-6161 1-(800)-339-7493 (Toll free)
Fax (918) 481-6181 1 (866) 364-7052 (Toll Free)
www.britulsa.com

Using your Benny™ Prepaid Benefits Card

After you enroll, you'll receive two Benny™ cards. Please sign them (your spouse can sign one) then activate them by calling the phone number or going to the website listed on the sticker on the card. The card will be activated within 48 hours.

With Benny™, you don't have to pay cash up front then wait for reimbursement. You do, however, need to **SAVE receipts for all expenses and you may need to submit the receipts for validation of the claim.**

Remember to select "Credit" when asked "Credit or Debit?" NO PIN is required! Just sign for your purchase. How convenient!

Swipe your benefits card **first** and only your FSA/HRA eligible purchases will be deducted from your account. Funds are immediately transferred from your FSA account at the time you incur the expense as long you have a balance in your account large enough to cover the claim.

For Office Visit Copays and Prescription Drug Copays: Just swipe the card and you're done as long as the copay matches for Office Visits and Prescription Drugs. If the copay doesn't match, be sure to get a receipt.

For Mail order Prescriptions: Provide the debit card number to the mail order vendor.

For Deductibles and Coinsurance under the medical and dental plans: Ask the provider to send you a bill for the balance **after** the insurance carrier for your health plan processes the claims. Write your Benny card number on the bill just like you would a credit card number and send it back. You will need to submit the itemized bill and insurance EOB to Benefit Resources.

For expenses not covered by the insurance plans: Like Lasik eye surgery or glasses. Use the debit card to pay for them and obtain an itemized receipt. Save the receipt.

For Eligible Over-the-Counter items not considered a medicine or a drug – you can use the debit card for these expenses. You can pay for them with Benny, but remember to save the itemized receipt.

SAVE YOUR CARDS to use next year! If you sign up again for a benefit associated with the Card next plan year you will simply keep using the same Card. Your new election amount will be available for you to use beginning the first day of the next plan year. The card does not expire for 5 years.

There's no need to activate in again! If you've already activated your Cards, you do not need to do so again. However, if you haven't activated your Cards yet, now's the perfect time to do so!

Save your itemized receipts! Your Plan Administrator may contact you to submit a receipt to verify a purchase. (Please send a receipt which clearly shows the merchant provider name, services received or item purchased, date of service and amount of the expense.) So, save your itemized receipts, and be sure to respond promptly so your Card remains active!

Be sure to use your Benny™ card only for eligible healthcare expenses!!

REQUEST FOR DOCUMENTATION LETTERS

If your Benny card charge does not match your company co-payment or was used at a pharmacy or drugstore other than an IIAS Merchant, you may receive a

REQUEST FOR DOCUMENTATION LETTER

Save your provider statements, Explanation of Benefit Statements (EOB) from your insurance carrier, and receipts to submit to Benefit Resources to document that your charge was:

- Incurred in the current plan year
- Was for an eligible participant
- Was for an eligible expense
- Was not paid by insurance or reimbursed from another plan

FIRST REQUEST FOR DOCUMENTATION

- If you provide documentation that satisfies the requirements listed above, your charge will be marked eligible.
- If the documentation is not satisfactory, you will receive a Request for More Information Letter.
- If the expense is determined to be ineligible, you will receive an Ineligible Expense Letter.
- If you do not respond within 14 days, you will receive a Second Request for Documentation

SECOND REQUEST FOR DOCUMENTATION

- If you provide documentation that satisfies the requirements listed above, your charge will be marked eligible.
- If the documentation is not satisfactory, you will receive a Request for More Information Letter.
- If the expense is determined to be ineligible, you will receive an Ineligible Expense Letter.
- If you do not respond within 14 days, you will receive a Possible Card Suspension Notification.

POSSIBLE CARD SUSPENSION NOTIFICATION

- If you provide documentation that satisfies the requirements listed above, your charge will be marked eligible.
- If the documentation is not satisfactory, you will receive a Request for More Information Letter.
- If the expense is determined to be ineligible, you will receive an Ineligible Expense Letter.
- If you do not respond within 7 days, your card will be suspended.

REQUEST FOR MORE INFORMATION LETTER

- If you provide the additional documentation that satisfies the requirements listed above, your charge will be marked eligible.
- If you do not have the additional documentation, it will be necessary to repay the charge to your account.
- If you do not respond or repay the expense within 30 days, your card will be suspended.

INELIGIBLE EXPENSE LETTER

- It will be necessary to repay the charge to your account.
- If the expense is not paid within 30 days, your card will be suspended.

YOUR ACCOUNT AND THE WEB 24/7

- TO ***ACTIVATE*** YOUR BENNY CARD

  Call 1-866-898-9795
  Your card will be active in 48 hours
  OR
  On the web, go to www.britulsa.com
  Select 'Activate My Benny Card'
  Enter your Member ID (This is your social security number)
  Enter your zip code (The zip code of the address where your card was mailed)
  Read the information regarding My Use of Card Promises
  Enter your email address (This is not a mandatory field. You can leave blank)
  If you agree, click on the button 'I agree'
  Your card will be active in 48 hours

- TO ***SET UP*** YOUR ACCOUNT ON 'MY BENNY.COM'

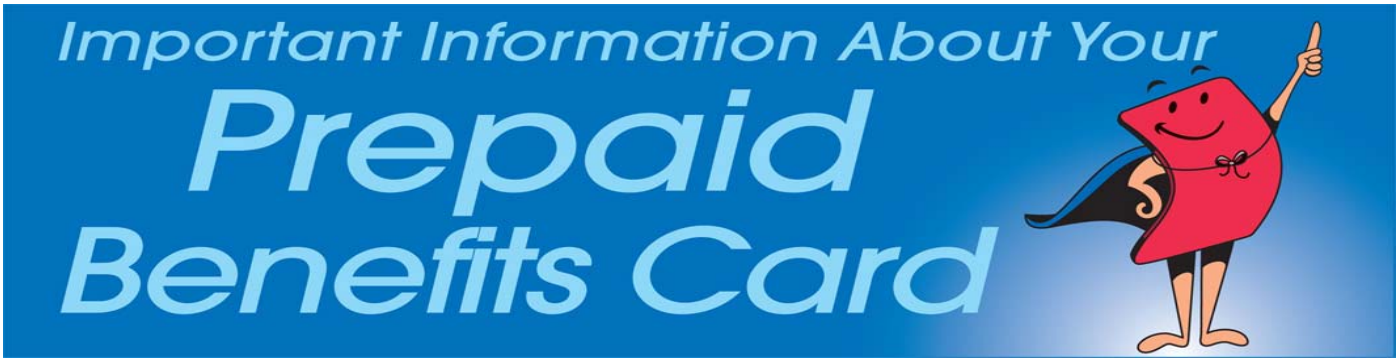
  On the web, go to www.mybenny.com
  Your first visit will require you to register at the login screen
  Click on **PLEASE REGISTER** to setup your account
  To confirm your account information you will need to enter:
  Your member ID (This is your social security number)
  Your card number (The sixteen digit number on your card)
  Your zip code (The zip code of the address where your card was mailed)
  Click on the button CONTINUE
  To create your User Account:
  Review your profile. If this information is not correct, please call
  Benefit Resources at (918) 481-6161 x 1 or (800) 339-7493 to request changes
  Enter your email address. (If you do not have an email address or you
  do not want to enter your email address, enter information in this
  format:johndoe@email.com. No communications will be sent to this address)
  Confirm the email address you entered
  Create your password for your account. It must be 8-15 characters and include one number
  Confirm your password
  Your account is now registered. You can click on click here to proceed into your account

- TO ***ACCESS*** YOUR ACCOUNT ON 'MY BENNY.COM'

  On the web, go to www.mybenny.com
  At the login screen, enter the email address you used to register your account
  Enter the password you created when you registered your account
  Click on the button 'LOGIN'
  You can now see your initial election, your remaining account balance and all the
  transaction activity of your FSA account (including manual paper claims).
  Using the menu options on the left, you can print a report of your account activity
  or file a protest if you think any transactions are in error.

- ***NEW IN 2012***

  Benefit Resources will have a new FSA website link accessible at www.britulsa.com/login
  Your first visit will require you to CREATE NEW ACCOUNT at the login screen
  Your username will be your SSN, your password will be the last 4 digits of your SSN
  Then you will be allowed to setup your own password
  The new website will allow you to check your balance, view your activity, change your address, and enter direct deposit information.
  BRI WILL SEND OUT ADDITIONAL INSTRUCTIONS AS THIS WEBSITE DEVELOPS!



GUIDELINES FOR THE USE OF FSA and HRA FUNDS TO PURCHASE OVER THE COUNTER PRODUCTS AFTER JANUARY 1, 2011

The recently enacted Patient Protection and Affordable Care Act of 2010 has changed the rules for the purchase of over the counter (OTC) products using your Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA) pre-tax funds.

As of January 1, 2011:

1. FSA and HRA funds can **no longer be used to purchase OTC medicine and drugs** unless a medicine or drug is prescribed. A "prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

   The OTC items affected include items in the following categories:

• Acid controllers	• Baby rash ointments/creams	• Laxatives
• Allergy & Sinus	• Cold sore remedies	• Motion sickness
• Antibiotic products	• Cough, cold & flu	• Pain relief
• Anti-diarrheals	• Digestive aids	• Respiratory treatments
• Anti-gas	• Feminine anti-fungal/itch	• Sleep aids & sedatives
• Anti-itch & insect bite	• Hemorrhoidal preps	• Stomach remedies
• Antiparasitic treatments		

2. If you have a prescription for an OTC medicine or drug, you must pay out of pocket at point of sale and then submit a manual claim requesting reimbursement. **You cannot use your Benny™ Prepaid Benefits Card for this purchase.** (NOTE: Some retail merchants may remove OTC drugs and medicines from their list of eligible items prior to the January 1 effective date, in which case these items will not be approved on the prepaid benefits card at those merchants.)

3. You can continue to use your FSA and HRA funds to purchase OTC items that are not considered a medicine or drug (e.g. bandages, splints, contact lens solution, etc.) Please note that **insulin remains an eligible expense** with or without a prescription. **So, your Benny Prepaid Benefits Card can continue to be used for these purchases.**

4. Remember to consider these new OTC rules when estimating the dollar amount to put in your FSA and HRA account for the next plan year.

For Internal Use Only: *Plan Year 1* *Plan Year 2*

HEALTH CARE REIMBURSEMENT ACCOUNT CLAIM FORM

Note: For First Time Orthodontics Claim, also see Orthodontic Worksheet

EMPLOYEE: _____ **SOCIAL SECURITY #**_____

EMPLOYER: **Oral Roberts University** **Email:**_____

HOME ADDRESS:_____

☐ *Please **X** if new address* *Street/Apt No.* *City* *State* *Zip*

HOME PHONE:_____ **WORK PHONE:**_____

The following documentation must accompany this claim form:

If expense is:	**Attach:**
▪ Covered by insurance *(including amounts applied to deductible)*	Explanation of Benefits **(EOB)**
▪ Not covered by insurance	Itemized receipt
▪ Office visit co-pay	Itemized receipt
▪ Prescription co-pay	Itemized receipt

Itemized receipt must document:
(☹Cancelled checks are not acceptable receipts)

- ➢ Date service was performed
- ➢ Description of service
- ➢ Service provider's name
- ➢ Service provider's address
- ➢ Person for whom service was provided
- ➢ Out-of-pocket cost to you

For each expense provide the following information **(***Remember:* ***Retain a copy of claim form & receipts for your records)***

	Date of Service	Type of Expense: Medical	Prescription	Vision	Dental	OTC	Expense covered by insurance: Yes, **Please submit EOB**	No	Is this a Co-payment: Yes	No	**Description of Service** or Comments *(Optional)*	**Amount of Out-of Pocket Expense**	*For Office Use Only* *Adjust*
1													
2													
3													
4													
5													
6													
7													

Total of claims	**$**
BRI adjustments	
BRI claims paid	

CERTIFICATION:

I certify the expenses on this Claim Form:

- are accurate and true
- are for a person covered under this Plan
- are eligible expenses which have not been previously reimbursed under this or any other benefit plan
- will not be claimed as an income tax deduction

Employee Signature:_____ **Date**:_____

I hereby authorize Benefit Resources, Inc. or its representatives to obtain information from all physicians, hospitals, medical service providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider the claim for reimbursement from my Flexible Spending Account.

Benefit Resources, Inc.

4775 E. 91st Street, Suite 100 Tulsa, OK 74137

Phone: (918) 481-6161 1 (800) 339-7493 (Toll Free)

Fax: (918) 481-6181 1 (866) 364-7052 (Toll Free)

www.britulsa.com

You may email scanned claims to: claims@britulsa.com

For Internal Use Only: Plan Year 1 Plan Year 2

DEPENDENT CARE REIMBURSEMENT ACCOUNT CLAIM FORM

(If all the information is completed on this claim form, no additional documentation is required.)

EMPLOYEE:_____ **SOCIAL SECURITY #**_____

EMPLOYER: **Oral Roberts University** **E-MAIL**_____

HOME ADDRESS:_____

☐ *Please **X** if new address* *Street/Apt No.* *City* *State* *ZIP*

HOME PHONE:_____ **WORK PHONE:**_____

DAY CARE PROVIDED FOR:_____

This is to certify that I have incurred Dependent Day Care expenses* in the amount of _____ for the period beginning_____and ending_____.

School tuition for kindergarten & higher grades is considered an educational expense and is **not eligible for reimbursement from the dependent day care account. Before-school care and after-school care are eligible expenses. The child must be 12 or under.*

Signature of Day Care Provider:_____

Federal Employer Identification Number **or** Social Security Number of Day Care Provider**:**_____

Address of Day Care Provider:_____

Please attach receipts to document the above information only if this form is not signed by the provider.

REMEMBER to retain a copy of this claim form for your records

CERTIFICATION: I certify the expenses on this Claim Form:

- are accurate and true
- are for a person covered under this Plan
- are eligible expenses which have not been previously reimbursed under this or any other benefit plan
- will not be claimed for an income tax credit.

Employee Signature:_____ Date:_____

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HEALTH CARE REIMBURSEMENT ACCOUNT

Orthodontic Pro Rata Worksheet and Claim Form

EMPLOYEE NAME:_____SSN:_____

EMPLOYER: Oral Roberts University

HOME ADDRESS:_____

Number/Street *City* *State* *Zip*

WORK SITE PHONE:_____HOME PHONE:_____

⇒THIS FORM NEEDS TO BE COMPLETED ONCE PER PLAN YEAR⇐

Complete this worksheet to pro rate the orthodontic treatment cost over the life of the orthodontic treatment.			
1.	Patient's Name:	_____	
2.	Date appliance installed		_____/_____/_____
3.	Expected date completion of treatment		_____/_____/_____
4.	Number of months of treatment	*Count number of months from installation to completion*	_____months
5.	Total cost of treatment	*Attach copy of Orthodontic contract*	**$**_____
6.	"Up-Front" costs: *(Examples: X-rays, evaluation and installation.)*	*Eligible for reimbursement when paid. Submit documentation for payment of Up-Front costs with this form or a Healthcare Reimbursement Claim form.*	**$(**_____**)**
7.	Insurance reimbursement	*Attach Dental Pre Authorization worksheet or Insurance Explanation of Benefits "EOB"*	**$(**_____**)**
8.	Expense to amortize over treatment period	*Subtract Line 6 and Line 7 from Line 5*	**$**_____
9.	Monthly Expense	*Divide Line 8 by Line 4*	**$**
☐	**Please check this box if you will using using your Benny™ Card to pay your monthly ortho expense**		

If you do not use your Benny™ Card to pay your ***Monthly Expense,*** it will be automatically reimbursed to you each month beginning with the first month of treatment *(or the first month of the plan year if this is a continuation of a previous claim)* until you have been paid the full amount of your annual election or the contract ends.

Under the rules of the Flexible Benefit Plan adopted by your employer, an expense is considered as having been incurred when the service is provided that gives rise to the expense, not when the expense is formally billed or paid. An employee may not be reimbursed in advance for the full cost of an ongoing treatment because the full service has not been completed.

Orthodontist Name: *(Please print)*_____ **Phone:**_____

Orthodontist Signature:_____**Date:**_____

Attach a copy of the Orthodontic Contract to this form

Employee Signature:_____**Date:**_____

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AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF FLEX SPENDING REIMBURSEMENTS

Company Name: Oral Roberts University

I hereby authorize BENEFIT RESOURCES to initiate deposit to the bank account indicated below. I authorize credit entries and, if necessary, debit entries and adjustment for any credit entries made in error to my account.

This account is: (Please check one of the following options)

New _____ Change_____ Cancel_____

_____ Transit ABA Routing #

_____ Account Number

_____ Account Type (Checking or Savings)

Name of Bank:_____

Bank Address:_____

_____

Bank Phone:_____

This authority is to remain in full force and effect until BENEFIT RESOURCES has received written notification from me of its termination in such time and in such manner as to afford BENEFIT RESOURCES and Depository a reasonable opportunity to act on it.

_____ Please Print Your Name

_____ Social Security Number

_____ Signature

_____ Date

Mail the completed form and a copy of a voided check (for checking accounts) or a deposit slip (for savings accounts) to:

BENEFIT RESOURCES, INC.
4775 E. 91st Street, Suite 100
Tulsa, OK 74137-2804
Fax To: 918-481-6181 (Local Fax)
1-866-364-7052 (Toll Free Fax)